APPLICATION FOR FEDERAL ASSISTANCE

APPLICATION FACE SHEET

FORM 1
OMB Approval No. 0348-0043

1. TYPE OF SUBMISSION:	Application	Preapplication
	☐ Construction	☐ Construction
	☒ Non-Construction	☐ Non-Construction

2. DATE SUBMITTED	Applicant Identifier
07/14/02	
3. DATE RECEIVED BY STATE	State Application Identifier
4. DATE RECEIVED BY FEDERAL AGENCY	Federal Identifier

5. APPLICANT INFORMATION

Legal Name:
State of California

Organizational Unit:
Title V Agency: MCH Branch/CMS Branch

Address *(give city, county, state, and zip code)*:
Department of Health Services
714 P Street
Sacramento, CA 95814

Name and telephone number of the person to be contacted on matters involving this application *(give area code)*
MCH: Gilberto Chavez, M.D. (916) 657-1347
CMS: Maridee Gregory, M.D. (916) 654-0832

6. EMPLOYER IDENTIFICATION NUMBER (EIN):
6 8 – 0 3 1 7 1 9 1

7. TYPE OF APPLICANT: *(enter appropriate letter in box)* A

A. State
B. County
C. Municipal
D. Township
E. Interstate
F. Intermunicipal
G. Special District
H. Independent School Dist.
I. State Controlled Institution of Higher Learning
J. Private University
K. Indian Tribe
L. Individual
M. Profit Organization
N. Other (Specify) _____

8. TYPE OF APPLICATION:
☒ New ☐ Continuation ☐ Revision

If Revision, enter appropriate letter(s) in box(es): ☐ ☐
A. Increase Award B. Decrease Award C. Increase Duration
D. Decrease Duration Other *(specify)*:

9. NAME OF FEDERAL AGENCY:
Health Resources & Services Administration
Maternal & Child Health Bureau

10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: 9 3 – 9 9 4
TITLE: Maternal & Child Health Services Block Grant

11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT:
Title V Block Grant Agency
State of California
Department of Health Services
Maternal and Child Health Branch and
Children's Medical Services Branch

AREAS AFFECTED BY PROJECT *(cities, counties, states, etc.)*:
tate of California

13. PROPOSED PROJECT:		14. CONGRESSIONAL DISTRICTS OF:	
Start Date	Ending Date	a. Applicant	b. Project
10/01/02	09/30/03	All California districts (current 1-45)	Same as 14a

15. ESTIMATED FUNDING:		
a. Federal	$	44,289,287 .00
b. Applicant	$	5,304,918 .00
c. State	$	777,395,553 .00
d. Local	$	.00
e. Other	$	1,316,400 .00
f. Program Income	$	575,718,071 .00
g. TOTAL	$	1,404,024,229 .00

16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?
a. YES. THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON
DATE
b. NO. ☒ PROGRAM IS NOT COVERED BY E.O. 12372
☐ OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW

17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?
☐ Yes If "Yes," attach an explanation. ☒ No

18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT. THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED

a Typed Name of Authorized Representative	b Title	c Telephone number
Gilberto Chavez M.D.; Maridee Gregory, M.D.	Chief, MCH Branch; Chief, CMS Branch	(916) 657-1347

nature of Authorized Representative: Gil Chavez MD Maridee Gregory MD
e Date Signed: 7/11/02

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Standard Form 424 (Rev 4-88)
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